MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9599

CERTIFICATE OF DEATH

Reg. Dist. No. 09602

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6month 29days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (14) 3V01.4
STREET ADDRESS (If rural give location) 5106 Richard Avenue √

3. NAME OF DECEASED: (Type or Print) (First) LILLIE (Middle) BLANCHE (Last) ALBERT

4. DATE OF DEATH: (Month) October (Day) 27 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2-12-77
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank M. Sturgeon
14. MOTHER'S MAIDEN NAME: Martha Underwood Sturgeon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic Heart Disease — Years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain dis., 6½Yr.+ with psychotic reaction.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Hospital
21C. WHERE DID INJURY OCCUR? (City or town) Sykesville (County) Carroll (State) Md.
21D. TIME OF INJURY (Month) 7 (Day) 24 (Year) 55 (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☒
21F. HOW DID INJURY OCCUR? Pt. Accidently slipped on floor.

22. I hereby certify that I attended the deceased from 9-10, 1955, to 10-27, 1955, that I last saw the deceased alive on 10-26, 1955, and that death occurred at 4:25AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustbader M. D. ADDRESS Springfield State Hospital DATE SIGNED 10-27-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-31-55
NAME OF CEMETERY OR ~~CREMATORY~~ Greenmount
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 28, 1955
REGISTRAR'S SIGNATURE C. Henry Lied
24. FUNERAL DIRECTOR H. Sanders Son
ADDRESS North & Broadway.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09603

9600 CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithers

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md — COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithers

STREET ADDRESS (If rural give location): X

3. NAME OF DECEASED (Type or Print): (First) John (Middle) James (Last) Anthony

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 5, 1904

9. AGE last birthday: 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Male Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Springfield Hospital

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John J. Anthony

14. MOTHER'S MAIDEN NAME: Mary C. Cullen

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: 212-03-2988

17. INFORMANT & ADDRESS: Mrs Agnes Anthony - Gaithers, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

Immediate cause (a) Cardiac Arrest, Coronary Occ — Interval Between Onset And Death: Sept 55 to Oct 55

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Generalized Metastases - Cerebral

DUE TO

(c) Metastases.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1955, to Oct 21, 1955, that I last saw the deceased alive on 21 Oct., 1955, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Howard E Bacon MD — ADDRESS: Sykesville — DATE SIGNED: 21 Oct 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE THEREOF:** 10-24-55 — **NAME OF CEMETERY OR ~~CREMATORY~~:** Springfield — **LOCATION (City, town, or county) (State):** Sykesville, Carroll, Md.

DATE REC'D BY LOCAL REGISTRAR: Oct 24, 1955 — **REGISTRAR'S SIGNATURE:** C. Harry Klee — **24. FUNERAL DIRECTOR** — **ADDRESS:** Luther H. Haight - Sykesville, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9601

CERTIFICATE OF DEATH

09604
Reg. Dist. No. 2E

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (in this place) 5 0 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Mills

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) Spring Mills

3. NAME OF DECEASED: (Type or Print) (First) LAURA (Middle) C. (Last) BABYLON

4. DATE OF DEATH: (Month) Oct. (Day) 2 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: August 19-1877

9. AGE last birthday: 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Christopher S Pickett

14. MOTHER'S MAIDEN NAME: Ellen Stonesifer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Earl Babylon Spring mills, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Myocarditis (chr.) Hypertension (chr.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1930, to 10-2-1955, that I last saw the deceased alive on 10-2-1955, and that death occurred at 10.45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. C. Jeannette MD, — ADDRESS 103 E Main Westminster — DATE SIGNED 10-3-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Oct. 6, 1955 — NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery — LOCATION (City, town, or county) (State) Westminster Md.

DATE REC'D BY LOCAL REGISTRAR 10-3-55 — REGISTRAR'S SIGNATURE Hamil Miller

24. FUNERAL DIRECTOR H. Bankard Son — ADDRESS Westminster, Md.

Dr Jeannette

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09605

9692 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X rural Westminster
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 08 R. 6

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Westminster X
STREET ADDRESS (If rural give location): R. 6 1

3. NAME OF DECEASED: (First) Madie (Middle) Jane (Last) Bollinger

4. DATE OF DEATH: (Month) Oct. (Day) 14 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 29, 1876

9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Arnold

14. MOTHER'S MAIDEN NAME: Mary Grimes

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service): - - - - -

16. SOCIAL SECURITY NO.: - - - - - - -

17. INFORMANT & ADDRESS: Hayden C. Bollinger R 6 Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 4 days.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerosis with Hypertension — years.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 10, 1955, to Oct. 14, 1955, that I last saw the deceased alive on Oct 13 1955, and that death occurred at 11 30 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James I. Mooch M.D. Westminster Md 10/14/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 17, 1955 — NAME OF CEMETERY OR CREMATORY: Deer Park — LOCATION (City, town, or county) (State): Smallwood Maryland

DATE REC'D BY LOCAL REGISTRAR: Oct 18 1955 — REGISTRAR'S SIGNATURE: Harold Miller

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09606

9603 CERTIFICATE OF DEATH Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 6 Smallwood

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Westminster
STREET ADDRESS (If rural give location) R 6 Smallwood

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) Ellen (Last) Bowers

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 1, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph E. Hess

14. MOTHER'S MAIDEN NAME: Belinda Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) - - - - -

16. SOCIAL SECURITY No.: - - - - - - -

17. INFORMANT & ADDRESS: Mrs. C. Albert Frick 6 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a) acute cardiac Decompensation — Interval Between Onset And Death: 1-5 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cerebral Hemorhage — 4 days

DUE TO

(c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2, 1955, to 10-6, 1955, that I last saw the deceased alive on 10-5, 1955, and that death occurred at 7.25 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas R Fouty M.D. ADDRESS Westminster Md DATE SIGNED 10.6.55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct. 8, 1955 NAME OF CEMETERY OR CREMATORY Deer Park LOCATION (City, town, or county) (State) Samllwood Maryland

DATE REC'D BY LOCAL REGISTRAR 10-7-55 REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR ADDRESS John R. Byers Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9604

CERTIFICATE OF DEATH

09607

Reg. Dist. No. 14

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington 15-2
STREET ADDRESS (If rural give location) 4502 Woodfield Road

3. NAME OF DECEASED: (First) MARGARET (Middle) O. (Last) BRIDEN
4. DATE OF DEATH: (Month) 10 (Day) 5 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: 12/27/76
9. AGE last birthday 78 yrs. IF UNDER 1 YEAR Months 5 Days 8 IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Lang
14. MOTHER'S MAIDEN NAME: Margaret Osborne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0
IMMEDIATE CAUSE (A) Acute Pulmonary Embolism — Hours
DUE TO
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) General Arteriosclerosis — Years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease, with psychotic reaction — 5 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
21C. WHERE DID INJURY OCCUR? (City or town) Kensington (County) Montgomery (State) Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-27-55 M.
21E. INJURY OCCURRED While at work [ ] Not while at work [X]
21F. HOW DID INJURY OCCUR? Unknown

22. I hereby certify that I attended the deceased from 9/8, 19 55 to 10/5, 19 55 that I last saw the deceased alive on 10/4, 19 55, and that death occurred at 8:30 A M. est, from the causes and on the date stated above.

SIGNATURE Edward Luskens M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/5/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal for Burial — DATE THEREOF 10-10-55 — NAME OF CEMETERY OR CREMATORY Moschessic Cemetery — LOCATION (City, town, or county) Providence, County (State) R.I

DATE REC'D BY LOCAL REGISTRAR Oct. 6, 1955 — REGISTRAR'S SIGNATURE C. Harry Weir

24. FUNERAL DIRECTOR Robert A. Pumphrey — ADDRESS Asst. Bithrode

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

9605

09608

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR X TOWN Union Town
LENGTH OF STAY (in this place) 33 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Town X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) E (Last) Burall
4. DATE OF DEATH: (Month) Oct. (Day) 24 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7-9-1864
9. AGE last birthday: 91 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jeremiah Peck
14. MOTHER'S MAIDEN NAME: Barbara Gingling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Amy Burall - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 422.2 Myocarditis (chr) Nephritis (chr)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Cerebral hemorrhage
(c)

INTERVAL BETWEEN ONSET AND DEATH: 7 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1940, to Oct 24, 1955, that I last saw the deceased alive on Oct 22, 1955, and that death occurred at 3.30 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. C. Jennie M.D. ADDRESS: Westminster Md DATE SIGNED: Oct-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10-26-1955 | NAME OF CEMETERY OR CREMATORY: Byington Rose | LOCATION (City, town, or county) (State): Frederick Co. Md.

DATE REC'D BY LOCAL REG.: 10/25/55 | REGISTRAR'S SIGNATURE: Margaret K. England | 24. FUNERAL DIRECTOR: C. M. Watts | ADDRESS: Winfield, Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09609

9616

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 42 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfiel d State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Prince George
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ???? 16 X - 2
STREET ADDRESS (If rural give location) ????

3. NAME OF DECEASED: (First) Betts (Middle) —— (Last) Butts
4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 1955

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): ???
8. DATE OF BIRTH: about 1871
9. AGE last birthday ? 84 ? yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ????
10B. KIND OF BUSINESS OR INDUSTRY: ????
11. BIRTHPLACE (State or foreign country): ????
12. CITIZEN OF WHAT COUNTRY? ????

13. FATHER'S NAME: ????
14. MOTHER'S MAIDEN NAME: ????

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ????
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. ????
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia, hebephr. type more than 42 yrs

19A. DATE OF OPERATION: ——
19B. MAJOR FINDINGS OF OPERATION ——
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ——
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ——
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY —— M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from Spt. 1, 1947, to Oct. 17, 1955, that I last saw the deceased alive on Oct. 16, 1955, and that death occurred at 6:00 AM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. M. D. ADDRESS Sykesville, Md DATE SIGNED Oct. 17, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL | DATE THEREOF OCT 17 1955 | NAME OF CEMETERY OR CREMATORY U OF M MEDICAL SCHOOL | LOCATION (City, town, or county) 29 S GREEN ST (State) MD.

DATE REC'D BY LOCAL REGISTRAR Oct. 18, 1955 | REGISTRAR'S SIGNATURE C Harry Deer | 24. FUNERAL DIRECTOR Duffield Bro ADDRESS 1800 E LOMBARD ST.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09610

9807 CERTIFICATE OF DEATH Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 415 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural give location) 530 Johannsen Street √

3. NAME OF DECEASED: (Type or Print) (First) Norwood (Middle) (Last) Calloway

4. DATE OF DEATH: (Month) 10- (Day) 9- (Year) 1955

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 5-30-1904

9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): New Orleans, Louisiana

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Samuel Calloway

14. MOTHER'S MAIDEN NAME: Arnita Gray

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212- 20-7901

17. INFORMANT & ADDRESS: Norwood Calloway - 530 Johannsen Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

002X

Immediate cause (a) Far advanced bilateral pulmonary tuberculosis

DUE TO with cavitation

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20-, 1954, to 10-9-, 1955, that I last saw the deceased alive on 10-9-, 1955, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) I. F. Rodal M.D ADDRESS Henryton, Maryland DATE SIGNED 10-9-55

23. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL DATE THEREOF OCT 11 1955 NAME OF CEMETERY OR CREMATORY U OF M MEDICAL SCHOOL LOCATION (City, town, or county) 29 S GREEN ST (State) MD

DATE REC'D BY LOCAL REGISTRAR 10-9-55 REGISTRAR'S SIGNATURE Albert R. Swinehamer

24. FUNERAL DIRECTOR Duffel Bro ADDRESS 1800 E LOMBARD ST.

VS. A15

09611

MARYLAND

STATE DEPARTMETT OF HEALTH

9608 CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine | LENGTH OF STAY (In this place) 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) EDWARD (Last) COLSON

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 3-4-1908

9. AGE last birthday: 47 (47) yrs. | If under 1 year: Months. Days. | If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B & O. R.R. Shops

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles O. Colson

14. MOTHER'S MAIDEN NAME: Mattie Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes | (If year, give war or dates of service) W.W.II

16. SOCIAL SECURITY NO.: 705-05-3371

17. INFORMANT AND ADDRESS: Ida May Crabb, Woodbine, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4

Immediate cause (a) Cardiac arrest, Coronary thrombosis,

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Congested heart disease, Cardiac edema.

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to 6 Oct, 1955, that I last saw the deceased alive on 6 Oct, 1955, and that death occurred at 5:30A m., from the causes and on the date stated above.

SIGNATURE Harold E Hall MD (Degree or title) ADDRESS Woodbine, Md. DATE SIGNED 6 Oct 55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE 10-10-1955 | NAME OF CEMETERY ~~OR CREMATORY~~ Morgan Chapel | LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REG. Oct. 9, 1955 | REGISTRAR'S SIGNATURE Robert R. Hewitt, Dpty.

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

9609

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09612

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster R 5 — LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Uniontown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster — X
STREET ADDRESS (If rural, give location) Westminster RD #5 — 1

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) (Last) CONOVICH
4. DATE OF DEATH: (Month) Oct (Day) 2 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 15, 1898
9. AGE last birthday: 57 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-10-5542
17. INFORMANT AND ADDRESS: Mrs. Anna S. Conovich, Westminster Md. RD#5

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

976 Immediate cause (a) Cerebral hemorrhage — minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home — (CITY OR TOWN) Westminster — (COUNTY) Carroll — (STATE) Md.
TIME OF INJURY (Month) Oct (Day) 2 (Year) 1955 (Hour) 3 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Self inflicted

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
James I. Wood — Deputy Medical Examiner — Westminster Md — Oct 3/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 5, 1955 — NAME OF CEMETERY OR CREMATORY: Meadow Branch — LOCATION (City, town, or county) (State): Rural, Westminster, Md.

DATE REC'D BY LOCAL REG. 10-3-55 — REGISTRAR'S SIGNATURE: Hamit Butler — 24. FUNERAL DIRECTOR — ADDRESS: J. S. Myers, Jr. — Westminster Md

09613

MARYLAND

STATE DEPARTMETT OF HEALTH

9610

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eldersburg.
MARYLAND
LENGTH OF STAY (in this place) 6 yrs; 6 mon.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
STREET ADDRESS (If rural, give location) Eldersburg.

3. NAME OF DECEASED (Type or Print): (First) Edgar (Middle) Roth (Last) Currens

4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 2-23-1884

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Male Nurse - Retired

10b. KIND OF BUSINESS OR INDUSTRY: Spring Grove Hospital

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Currens

14. MOTHER'S MAIDEN NAME: Amanda Sheffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS: Mrs Nettie Curren - Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Acute Coronary Thrombosis -

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Found dead on floor -

(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☑ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/27/55, 19..., to 10/27, 19..., that I ~~last saw the~~ did not see deceased alive on 10/27/55, 19..., and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE Reuben Bare (Degree or title) ADDRESS Deputy Coroner - Westminster, Md. DATE SIGNED 10/27/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 10-29-55 | NAME OF CEMETERY OR CREMATORY United Brethren | LOCATION (City, town, or county) (State) Thurmont, Md.

DATE REC'D BY LOCAL REG. Oct. 28, 1955 | REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Luther H. Haight | ADDRESS Sykesville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09614

9611 CERTIFICATE OF DEATH Reg. Dist. No. 82-83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural- Sykesville
LENGTH OF STAY (in this place) 42 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural--Sykesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Chester (Middle) (Last) Davis
4. DATE OF DEATH: (Month) Oct. (Day) 12 (Year) 1955
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH: 12-16-1887
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): carpenter
10b. KIND OF BUSINESS OR INDUSTRY: general
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Ira R. A. Davis Error
14. MOTHER'S MAIDEN NAME: Eva J. Henry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-12-1016
17. INFORMANT & ADDRESS: Mrs. Nina Davis, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cerebral hemorrhage — 18 hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cardio Vascular Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/12/, 1955, to 10/12/, 1955, that I last saw the deceased alive on 10/12/, 1955, and that death occurred at 1:05P:M, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm E. Martin, M.D. Randallstown Md 10/13/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF 10-15-1955 NAME OF CEMETERY OR CREMATORY Winfield Church Of God LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REGISTRAR Oct. 14. 1955 REGISTRAR'S SIGNATURE Robert R. Hewitt.

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09615

9612 **CERTIFICATE OF DEATH** Reg. Dist. No. 77

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Hampstead Rural
LENGTH OF STAY (in this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead. Rural x
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) ELLA (Middle) M (Last) DAWES

4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1955

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH: Nov 27-1878
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret
10B. KIND OF BUSINESS OR INDUSTRY: H.W.K
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Rhodes
14. MOTHER'S MAIDEN NAME: Ella Ecklauf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. ✓
17. INFORMANT & ADDRESS: Mrs Ethel White. Hampstead Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE (A)	Cerebral Hemorrhage	2 hrs
ANTECEDENT CAUSE (S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	Hypertensive C.V. Disease	15 yrs
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	old Cerebral Hemorrhage	7 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1948, to Oct 9, 1955, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 3p M, from the causes and on the date stated above.

SIGNATURE M. C. Porterfield M. D. ADDRESS Hampstead, Md DATE SIGNED 10-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-12-1955
NAME OF CEMETERY OR CREMATORY St Paul's
LOCATION (City, town, or county) (State) Balto co Md

DATE REC'D BY LOCAL REGISTRAR 10/9/55
REGISTRAR'S SIGNATURE Henry [illegible]
24. FUNERAL DIRECTOR Eli Tipton. ADDRESS Hampstead Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09616

9613

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster X
STREET ADDRESS (If rural give location) R.D. 5 1

3. NAME OF DECEASED: (Type or Print) (First) ELIZA (Middle) ANNIE (Last) DAY

4. DATE OF DEATH: (Month) October (Day) 1 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 8, 1894

9. AGE last birthday: 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John T. Edmunkson

14. MOTHER'S MAIDEN NAME: Nancy Jane Parrish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: John E. Day R.D. 5 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Cardiac Decompensation — Interval Between Onset And Death: 15 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Cardio-Renal disease — 2 yrs

DUE TO

(c)

442X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1955, to Oct 1, 1955 that I last saw the deceased alive on Sept 30 1955 and that death occurred at 2 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Fout M.D. — ADDRESS Westminster Md — DATE SIGNED Oct 3-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Oct. 4, 1955 — NAME OF CEMETERY OR CREMATORY Prondence Cemetery — LOCATION (City, town, or county) (State) Gamber, Md.

DATE REC'D BY LOCAL REGISTRAR 10-3-55 — REGISTRAR'S SIGNATURE Hazel Miller — 24. FUNERAL DIRECTOR A.H. Bankard & Son Westminster Md — ADDRESS

Dr. Fout

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09617

9614 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1month 3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~City~~ Balt.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (4) 03X-2
STREET ADDRESS (If rural give location) 510 Park Avenue √

3. NAME OF DECEASED: (Type or Print) (First) HERMAN (Middle) GEORGE (Last) DOMNOSKY

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: 11-25-80
9. AGE last birthday 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Veterinarian
10B. KIND OF BUSINESS OR INDUSTRY: Veterinary
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Ferdinand Domnosky
14. MOTHER'S MAIDEN NAME: Henrietta Domnoskey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk-
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X
IMMEDIATE CAUSE (A) Cerebral vascular accident — Days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis, general. — Years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with senile brain dis., with psychotic reaction. — 1½ months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23, 1955, to 10-19, 1955, that I last saw the deceased alive on 10-19, 1955, and that death occurred at 8:40AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustman, M.D. ADDRESS Springfield State Hosp. DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-22-55
NAME OF CEMETERY OR CREMATORY New Cathedral
LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 19, 1955
REGISTRAR'S SIGNATURE C. Harry Klein
24. FUNERAL DIRECTOR J. O. Mitchell & Sons. ADDRESS 1900 Eutaw Place.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09618

MARYLAND

9615

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll, Sykesville, Maryland — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural: Sykesville, Md. — LENGTH OF STAY (in this place) 1 Mo. 6days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City 13X-2
STREET ADDRESS (If rural, give location) Main Street √

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Ridgely (Last) Dyson

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 10-15-65

9. AGE last birthday: 90 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER (RET.)

10b. KIND OF BUSINESS OR INDUSTRY: FARM WORK

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Dyson

14. MOTHER'S MAIDEN NAME: Anna Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Occlusion — 5 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis — years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction — years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15, 19 55, to 10-21, 19 55, that I last saw the deceased alive on 10-21, 19 55, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

SIGNATURE Gertrude M. Gross M.D. (Degree or title) — ADDRESS Springfield State Hosp. Sykesville, Maryland — DATE SIGNED 10-21-1955

Gertrude M. Gross M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 10/24/55. — NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEM. — LOCATION (City, town, or county) (State): HOWARD County, Md.

DATE REC'D BY LOCAL REG. Oct. 21, 1955 — REGISTRAR'S SIGNATURE C. Harry Klee

24. FUNERAL DIRECTOR — ADDRESS: Easton Sons, Catonsville 28, Md.

9616 09619

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR X TOWN Sykesville
LENGTH OF STAY (in this place) 2month 28days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore (31) 3V01-4
STREET ADDRESS (If rural, give location) 1807 Bank Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	HENRY	EATON	OCTOBER	27	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	6-17-95	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farm work	Agriculture	Tennessee	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Samuel Eaton	Ellen Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Unk -	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Embolism	Days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Bilateral Bronchopneumonia	5 days
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with diseases of unknown or unspecified cause with psychotic reaction. — 3yrs.+

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospital	21c. (City or town)	(County)	(State)
		Sykesville	Carroll	Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
10 14 55 9a. M.		Pt. fell in shower room - fractured hip

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER / DEPUTY MEDICAL EXAMINER / ASSISTANT MEDICAL EXAM. DATE SIGNED 10/28/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Oct 28, 1955		FAIRFAX, VA.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 28, 1955	[signature]	J. S. Everly	Fairfax, VA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09620

9617

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 5/11/55
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ——
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-6
STREET ADDRESS (If rural give location) 1610 N. Calvert St.

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Williamson (Last) EDSON

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): unknown
8. DATE OF BIRTH: ~~unknown~~ 8-17-77
9. AGE last birthday ~~78~~ yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ——
10B. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): unknown Binghamton New York
12. CITIZEN OF WHAT COUNTRY? ~~unknown~~ U.S.

13. FATHER'S NAME: ~~unknown~~ William Edson
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ——
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0
IMMEDIATE CAUSE (A) Bronchopneumonia — 2 days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis DUE TO — more than 5 months
(C) ——

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease more than 5 mos.

19A. DATE OF OPERATION: ——
19B. MAJOR FINDINGS OF OPERATION ——
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ——
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ——
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ——
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from Aug. 11, 1955 to Oct. 19 1955, that I last saw the deceased alive on Oct. 19, 1955, and that death occurred at 7:18 P.M., from the causes and on the date stated above.
SIGNATURE ADDRESS DATE SIGNED
Merlin Sorg M.D. M.D. Sykesville, Md. Oct 21-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/24/55
NAME OF CEMETERY OR CREMATORY St. Peters Cem.
LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR October 22. 1955
REGISTRAR'S SIGNATURE R.W
24. FUNERAL DIRECTOR Wm. J. Pickerell & Sons
ADDRESS Balto 17 Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

9618

09621

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL MT AIRY
LENGTH OF STAY (in this place) 8 HRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BALTIMORE 3V01-4
STREET ADDRESS (If rural, give location) 337 S. STRICKER St

3. NAME OF DECEASED: (Type or Print) (First) AARON (Middle) - (Last) EVANS
4. DATE OF DEATH (Month) Oct (Day) 6 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Married	12-11-73	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST RET	B&O. R.R.	Md	

13. FATHER'S NAME: Hampton Evans
14. MOTHER'S MAIDEN NAME: Kate Barth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	RR.B.A36718	NANCY JANE EVANS 337 S. STRICKER St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	minutes
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis	years
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Mason M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 10/6/53

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	Oct 10-1953	MORGAN CHAPEL CEM	WOODBINE Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
10-7-53	[illegible]	Pratt & B. M. Walter Duke Pratt & Stricker Sts

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09622

9619

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville
LENGTH OF STAY (in this place) 6 Mos. 5 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural give location) 931 East 41st Street

3. NAME OF DECEASED: (Type or Print) (First) RUBY (Middle) B. (Last) GARDINER

4. DATE OF DEATH: (Month) 10 (Day) 6 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 3/27/85

9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James P. Wakeland

14. MOTHER'S MAIDEN NAME: Hannah S. McFadden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334 X

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 9 years?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21, 1955 to 10/6, 1955, that I last saw the deceased alive on 10/6, 1955, and that death occurred at 2 P EST M, from the causes and on the date stated above.

SIGNATURE Edmund Sutherland M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/6/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10/10/55 — NAME OF CEMETERY OR CREMATORY Cathedral — LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR October 8th 1955 — REGISTRAR'S SIGNATURE R.W. ✓

24. FUNERAL DIRECTOR MARTIN FAHEY & SONS — ADDRESS 401 Suffolk Rd.-18

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620 **CERTIFICATE OF DEATH** 09623

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1yr.5mo.22days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (13) 3V01-4
STREET ADDRESS (If rural give location) 2746 Pelham Avenue

3. NAME OF DECEASED: (Type or Print) (First) IDA (Middle) ANTOINETTE. (Last) GERNHART

4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 5-20-91
9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS
10B. KIND OF BUSINESS OR INDUSTRY: H.BERLIN CLOTHING CO
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Knorr
14. MOTHER'S MAIDEN NAME: ANNA ERPENSTEIN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) NO.
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 X IMMEDIATE CAUSE	(A) Uremia	two weeks
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Chronic Glomerulonephritis	years
	(C) DUE TO Hypertensive cardiovascular disease	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with disturbance of metabolism, growth or nutrition, presenile brain dis., with psychotic reaction. 2yrs. +

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1-, 1955, to 10-28, 1955, that I last saw the deceased alive on 10-27-55, 19..., and that death occurred at 8:22AM, from the causes and on the date stated above.

SIGNATURE Walther H. Schmidt M.D. ADDRESS Springfield State Hosp. DATE SIGNED 10-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Oct 31,1955
NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
LOCATION (City, town, or county) (State) Belair Rd.

DATE REC'D BY LOCAL REGISTRAR 10/31/55
REGISTRAR'S SIGNATURE H. Schmidt
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 2601-03-05 E. Madison Street

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09625

9596 CERTIFICATE OF DEATH Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Westminster 27
LENGTH OF STAY (in this place) 6 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 263 E. Main St. 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural give location) 263 E. Main 1

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) LESTER (Last) GUIDER
4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	June 25-1887	68 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Cleaner & Dyer	clothing	Md.	U.S.

13. FATHER'S NAME: George C. Guider
14. MOTHER'S MAIDEN NAME: Kate Wheat

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
yes	WW. I	213-09-8165	Mrs J.B. POTTORF Hopkinsville, Ky.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause 421.0	(a) Cardiac decompensation	10 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Mitral insufficiency	5 years
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 4, 1954, to Oct 9, 1955, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 10:35 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Julian Chenko M.D. ADDRESS 130 E Green, Westminster Md DATE SIGNED 10/11/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct. 12, 1955	Pine Creek Cemetery	Mt Wilson town	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-11-55	Harriet Reaver	A. Bankard & Son	Westminster Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09626

9622

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 5/14/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 10-35-2
STREET ADDRESS (If rural give location) 3 West "C" Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Henry (Last) HAHN

4. DATE OF DEATH: (Month) (Day) (Year) October 24 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower
8. DATE OF BIRTH: October 11, 1855
9. AGE last birthday 100 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10B. KIND OF BUSINESS OR INDUSTRY: ---Unk-
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0
IMMEDIATE CAUSE (A) Bronchopneumonia — 2 days
DUE TO
ANTECEDENT CAUSE (B) Generalized arteriosclerosis — about 2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO
(C) ---

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile brain disease — about 2 yrs.

19A. DATE OF OPERATION: ---
19B. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---
21E. INJURY OCCURRED While at work ☐ Not while at work ☐ ---
21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from May 29, 1954 to Oct. 24, 1955, that I last saw the deceased alive on Oct. 24, 1955, and that death occurred at 3:40P M, from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. ADDRESS Sykesville, Md. DATE SIGNED 10/24/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-27-55 — NAME OF CEMETERY OR CREMATORY Park Heights — LOCATION (City, town, or county) (State) Brunswick, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 25, 1955 — REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR C. N. Fiete Bros. — ADDRESS Brunswick, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9623 09629

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balto. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City #6
STREET ADDRESS (If rural give location) 2400 Bowleys Lane

3. NAME OF DECEASED: (Type or Print) (First) BESSIE (Middle) Elizabeth (Last) HALL

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: Fe
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: 5-24-99
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR Months 4 Days 28 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Chester
14. MOTHER'S MAIDEN NAME: Sadie Diamond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-18-8784
17. INFORMANT & ADDRESS: Ruth Huth (daughter) 2400 Bowleys Lane, Balto, 6

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

321X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage sec. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S) DUE TO Arteriosclerosis and Hypertension — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with Arteriosclerosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 1955 to 10-22, 1955 that I last saw the deceased alive on 10-22, 1955, and that death occurred at 10:35 PM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeld M.D. ADDRESS Springfield State Hospital DATE SIGNED 10/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
DATE THEREOF 10-26-55
NAME OF CEMETERY OR CREMATORY OAK LAWN CEM
LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.

DATE REC'D BY LOCAL REGISTRAR 10/25/55
REGISTRAR'S SIGNATURE C. W. Hedrick
24. FUNERAL DIRECTOR Charles S. Zeller
ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09627

9624 CERTIFICATE OF DEATH

Reg. Dist. No. 7H

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2) 3Y01-4
STREET ADDRESS (If rural give location) 514 East Pratt Street V

3. NAME OF DECEASED: (Type or Print) (First) NELSON (Middle) CROMWELL (Last) HAM

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Sep.

8. DATE OF BIRTH: 8-3-19

9. AGE last birthday: 36 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel clerk

10B. KIND OF BUSINESS OR INDUSTRY: Hotels

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Henry Ham

14. MOTHER'S MAIDEN NAME: Maude Elizabeth — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) ?

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.1
IMMEDIATE CAUSE (A) Hepato-renal syndrome — several days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) liver cirrhosis — not known
DUE TO (C) chronic Alcoholism — Yrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with alcohol intoxication, with psychotic reaction. — Years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1955, to 10/12/, 1955, that I last saw the deceased alive on 10/12/, 1955, and that death occurred at 1110 PM, from the causes and on the date stated above.
SIGNATURE Walther H. Sommerfeldt. M. D. ADDRESS Springfield State Hospital DATE SIGNED 10-13-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-17-55
NAME OF CEMETERY OR CREMATORY Staunton
LOCATION (City, town, or county) (State) Staunton, Va.

DATE REC'D BY LOCAL REGISTRAR Oct. 14, 1955
REGISTRAR'S SIGNATURE C. Harry Deer
24. FUNERAL DIRECTOR Luther A. Haight ADDRESS Sykesville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9597 **CERTIFICATE OF DEATH** Reg. Dist. No. 09628

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster
LENGTH OF STAY (in this place) 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Anita Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 10 Anita Drive

3. NAME OF DECEASED: (First) MARGARET (Middle) MERRITT (Last) HAMILL
4. DATE OF DEATH: (Month) (Day) (Year) Dec 14 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	Jan. 12, 1911	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
at home		Baltimore, Maryland	USA

13. FATHER'S NAME: Ethington Merritt
14. MOTHER'S MAIDEN NAME: Annie Pohler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Mr. Leslie W. Hamill, 10 Anita Dr. Westminster

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
175X Immediate cause	(a) Carcinoma Ovary.	2 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
Nov 11 1953	Carcinoma Ovary	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Sept. 1955 to Dec 14 1955, that I last saw the deceased alive on Dec 13 1955, and that death occurred at 3:25 P.m., from the causes and on the date stated above.

SIGNATURE James J. Marsh (DEGREE OR TITLE) M.D. ADDRESS Westminster Md DATE SIGNED Dec 14-1955

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 18, 1955	Woodlawn Cemetery	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
DS - 17-55	[illegible]	Leonard J. Ruck, 5305 Harford Road #14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09630

9625 CERTIFICATE OF DEATH Reg. Dist. No. 74 WS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Henryton
LENGTH OF STAY (in this place) 5 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3Y01-4
STREET ADDRESS (If rural give location) 551 Orchard Street ✓

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) P. (Last) Harris
4. DATE OF DEATH: (Month) 10- (Day) 4- (Year) 1955

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 8-9-1900
9. AGE Last birthday: 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private Home
11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Fletcher Tyler
14. MOTHER'S MAIDEN NAME: ???? Parker

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Daisy P. Harris - 551 Orchard Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause: 002X (a) Far advanced bilateral pulmonary tuberculosis with cavitation

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Cardiovascular disease

(c) DUE TO

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-29-, 1955, to 10-4-, 1955, that I last saw the deceased alive on 10-4-, 1955, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE I. F. Total (Degree or title) M. D ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL DATE THEREOF OCT 10 1955 NAME OF CEMETERY OR CREMATORY U of M MEDICAL SCHOOL LOCATION (City, town, or county) 295 GREENE ST (State) MD ADDRESS

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE Albert R. Swarthout

24. FUNERAL DIRECTOR Duffy Bros. 1800 E LOMBARD ST.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09631

9626

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. | LENGTH OF STAY (in this place) 53 y
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: Md. STATE COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Johanna (Middle) (Last) HESSLER

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Mln.
F	W			87 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) Coronary Occlusion	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Hypertensive Cardio-Vascular	
	DUE TO (C) Desease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Schizophrenia	

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1912, to 10-8, 1955, that I last saw the deceased alive on 10-7, 1955, and that death occurred at 640 a.M, from the causes and on the date stated above.

SIGNATURE A. Lubeigha M. D. ADDRESS Springfield Md. DATE SIGNED 10/8/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
REMOVAL	OCT 17, 1955	U of M MEDICAL SCHOOL	29 S GREEN ST MD

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 18, 1955	C. Harry Theeg	Dubbel Bros.	1800 E LOMBARD ST

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9627

CERTIFICATE OF DEATH

09632

Reg. Dist. No. 74

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton

LENGTH OF STAY (in this place): 16 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY:

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

STREET ADDRESS (If rural give location): 1321 Presstman Street

3V01-4

3. NAME OF DECEASED (Type or Print): (First) Mabel (Middle) (Last) Jackson

4. DATE OF DEATH: (Month) 10 (Day) 29 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Colored	Married	12-17-04	50 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Emporia, Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Junius Wyche	Della Caine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		None	Deceased

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

019.2 IMMEDIATE CAUSE (A) Dense Miliary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Cardiac Insufficiency

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 13, 1955, to Oct. 29, 1955, that I last saw the deceased alive on Oct. 29, 1955, and that death occurred at 6.00 P.M, from the causes and on the date stated above.

SIGNATURE T. F. Vestal M.D M.D. — **ADDRESS** (Street, city, town, state) Henryton, Md. — **DATE SIGNED** 10-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buriel	11-4-55	Mt Calvary	Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
10-29-55	Albert R. Swankhaus	George S. Kelson	1345 N. Calhoun St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09634

9628

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 5Y 3M 27 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY B
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Vol-4
STREET ADDRESS (If rural give location) 1348 Glyndon Avenue

3. NAME OF DECEASED: (First) IRVIN (Middle) JOHN (Last) KNAPP

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 7/30/01
9. AGE last birthday 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Broom shop
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin Benjamin Knapp
14. MOTHER'S MAIDEN NAME: Catherine Easter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.1

IMMEDIATE CAUSE (A) Gangrene of both legs — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis — 5 years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with mental deficiency — Psychosis-5 Y M. D.- life

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/25, 1954 to 10/12, 1955, that I last saw the deceased alive on 10/12, 1955, and that death occurred at 7:05 AM EST, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnendeckl, M.D. ADDRESS Glen, Maryland Sykesville, Maryland DATE SIGNED 10/12/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-15-55
NAME OF CEMETERY OR CREMATORY William. Cook Inc
LOCATION (City, town, or county) 1317 St. Paul St. (State)

DATE REC'D BY LOCAL REGISTRAR 10-13-55
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09635

9529

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 4/30/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY —
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 806 S. Bond Street

3. NAME OF DECEASED: (Type or Print) (First) Stanley (Middle) - (Last) KOPEC

4. DATE OF DEATH: (Month) October (Day) 11 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: February 8, 1876
9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: O— Unk -
11. BIRTHPLACE (State or foreign country): Poland (naturalized)
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Frank Kopec
14. MOTHER'S MAIDEN NAME: Mary - Unk -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 IMMEDIATE CAUSE	(A) Bronchopneumonia	4 days
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Generalized arteriosclerosis - more	than 3 yrs.
	DUE TO (C) —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH	Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction	more than 3 yrs.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. —
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 26 1952 to Oct. 11 1955, that I last saw the deceased alive on Oct. 11, 1955, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. Martin Gross, M.D. ADDRESS Sykesville, Maryland DATE SIGNED 10/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-17-55
NAME OF CEMETERY OR CREMATORY Springfield
LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 17, 1955
REGISTRAR'S SIGNATURE C. Harry Wise
24. FUNERAL DIRECTOR Arthur N. Wright
ADDRESS Sykesville Md.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09636

9630

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 23Y 6M 1D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 14 3V01-4
STREET ADDRESS (If rural give location) 3007 Overland Avenue

3. NAME OF DECEASED: (Type or Print) (First) Pauline (Middle) B. (Last) Korn

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: 9 - 24 - 77

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Broghamer

14. MOTHER'S MAIDEN NAME: Mary Becker Enderman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unk

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 9047	(A) Septicemia due to decubitus ulcers	Weeks
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Subcapital fracture of femur	4 months
	DUE TO (C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia Paranoid Type — 23 years

19A. DATE OF OPERATION: 6-30-55

19B. MAJOR FINDINGS OF OPERATION Surgical fracture of femur-Well-leg splint

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ward

21C. WHERE DID INJURY OCCUR? (City or town) Sykesville (County) Carroll (State) Md

21D. TIME OF INJURY (Month) 6-14 (Day) -55 (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☒

21F. HOW DID INJURY OCCUR? Pt. fell while going for supper

06

22. I hereby certify that I attended the deceased from 6-14-55, 19..., to 10-22-..., 1955, that I last saw the deceased alive on 10-22-..., 19..., and that death occurred at 4:55 PM, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M. D. — ADDRESS Springfield State Hospital — DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-25-55	Parkwood Cem.	Balto Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 23, 1955	C. Harry Mills	Leonard J. Buck 5305	Harford

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09637

9598

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Westminster

LENGTH OF STAY (in this place) 1 Mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 Anchor St.,

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4

STREET ADDRESS (If rural, give location) 4029 Wilkens Ave.,

3. NAME OF DECEASED: (Type or Print) (First) EDMUND (Middle) A. (Last) LEIDENROTH

4. DATE OF DEATH: (Month) Dec (Day) 15 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widower	Aug. 12, 1886	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Tool Keeper	Manufacturing	Md.	

13. FATHER'S NAME: August F.Leidenroth

14. MOTHER'S MAIDEN NAME: Catherina Nordhoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	217-22-2879	Mrs.Lawrence C.Card 121 Anchor St., Westminster,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

163X

Immediate cause (a) Leiomyoma Lung — Interval between onset and death: 3 mos

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Sept 14, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 15 1955, 19....., and that death occurred at 11:15 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

James J Monk M.D. Westminster Md 10/17/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-17-1955	Lorraine Park	Woodlawn, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-17-55		G.Howard Strong	3207 W.North Ave.,

09638

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9631 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: Sykesville
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville
LENGTH OF STAY (in this place): 7 months 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsport 21X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Michael (Last) LisKey

4. DATE OF DEATH: (Month) 10 (Day) 23 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Sep.
8. DATE OF BIRTH: 4/2/83
9. AGE last birthday: 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Clinton Liskey
14. MOTHER'S MAIDEN NAME: Ida C. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 214-09-4532
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
023X
IMMEDIATE CAUSE (A) Chronic valvular disease (aortic valve stenosis) — INTERVAL BETWEEN ONSET AND DEATH: years
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Systemic Syphilis — years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. G.P.I. Syphilitic meningoencephalitis — years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2, 1955, to 10/23, 1955, that I last saw the deceased alive on 10/23, 1955, and that death occurred at 9:05 P.M., from the causes and on the date stated above.
SIGNATURE Gertrude M. Gross, M.D. M. D. ADDRESS Sykesville, Md DATE SIGNED 10/24/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
DATE THEREOF: Oct 28/55
NAME OF CEMETERY OR CREMATORY: Rose Hill
LOCATION (City, town, or county) (State): Hagerstown Md

DATE REC'D BY LOCAL REGISTRAR: Oct. 24, 1955
REGISTRAR'S SIGNATURE: C. Harry Weed
24. FUNERAL DIRECTOR: A K Hoffman ADDRESS: Hagerstown Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09639

9632

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Rural Sykesville, Maryland
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 1 Mo. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural: Sandy Spring, Maryland
STREET ADDRESS (If rural give location) 15X-2

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) Bruce (Last) Lockyer

4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid.

8. DATE OF BIRTH: 7-10-78

9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk -

10B. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Bruce

14. MOTHER'S MAIDEN NAME: Mary Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 023X
(A) Myocardial Insufficiency — days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO
(B) Generalized arteriosclerosis — years
DUE TO
(C) Systemic syphilis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with arteriosclerosis, with psychotic reaction — cerebral years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14, 19 55, to 10-19, 19 55, that I last saw the deceased alive on 10-19, 19 55, and that death occurred at 2:20 A M, from the causes and on the date stated above.

SIGNATURE Gertrude M. Gross, M.D. — ADDRESS — DATE SIGNED
M. D. Springfield State Hospital 10-19-1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-21-55
NAME OF CEMETERY OR CREMATORY Cedar Hill cemetery
LOCATION (City, town, or county) Suitland (State) Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 19, 1955
REGISTRAR'S SIGNATURE C. Harry Wilt
24. FUNERAL DIRECTOR S H Hines
ADDRESS Washington DC

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09640

9633

Item 7, FilmG188 11-4-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rual
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Baltimore Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Rual
STREET ADDRESS (If rural give location) Old Baltimore Road

3. NAME OF DECEASED: (Type or Print) (First) ELSIE (Middle) Myrtle (Last) Mann

4. DATE OF DEATH: (Month) Oct. (Day) 25 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Dec. 8, 1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Arnold

14. MOTHER'S MAIDEN NAME: Ida Gamber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: James R. Mann, Westminster, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.2 IMMEDIATE CAUSE	(A) Pulmonary Fibrosis.	3 yrs.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Myocarditis	5 yrs
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	abdominal adhesions	1½ yrs

19A. DATE OF OPERATION: June 13, 1954

19B. MAJOR FINDINGS OF OPERATION: Sub-acute appendix & abdominal adhesions

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY none

21C. WHERE DID INJURY OCCUR? (City or town) none (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) none M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ none

21F. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from Jan. 5, 1943, to Oct. 25, 1955, that I last saw the deceased alive on Oct. 25, 1955, and that death occurred at 8:30 P M, from the causes and on the date stated above.

SIGNATURE M. D. J. D. Caplis ADDRESS Reisterstown, Md. DATE SIGNED 10-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF Oct. 28.55 NAME OF CEMETERY OR CREMATORY Calvary Cemetery LOCATION (City, town, or county) (State) Gamber, Carroll Co. Md.

DATE REC'D BY LOCAL REGISTRAR 10-29-55 REGISTRAR'S SIGNATURE Hazel Keller

24. FUNERAL DIRECTOR J. E. Myers Jr. ADDRESS Westminster Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

9634

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Mt. Airy

LENGTH OF STAY (In this place) 36 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Frederick

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Mt. Airy 10 x - 2

STREET ADDRESS (If rural, give location) Hill St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
BERTHA	EVANS	MERRICK	10/18/ 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	widowed	12-23-1890	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
housewife	own home	Maryland	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Rickard Evans	Elizabeth Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		none	Mrs. Nicholas Knott, Hillsboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

825 X

Immediate cause (a) Crushing injury of chest with rupture of heart

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY street	21c. (City or town) (County) (State) Carroll Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/18/55 10:15 A.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? Driver - lost control of car

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R B Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 10/18/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10-21-1955	Greenmount	Queen Anne Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-20-55	Robert R. Hewitt.	C. M. Waltz,	Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09642

9635 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 17 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 409 Brown Ave

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) E (Last) Miller

4. DATE OF DEATH: (Month) 10 (Day) 1 (Year) 1955

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married | 8. DATE OF BIRTH: 5-13-88 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known | 10B. KIND OF BUSINESS OR INDUSTRY: Unk- | 11. BIRTHPLACE (State or foreign country): not known | 12. CITIZEN OF WHAT COUNTRY? Unk-

13. FATHER'S NAME: not known | 14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) yes. (If Yes, give war or dates of service) 1907 to 1911 Marine Corps. | 16. SOCIAL SECURITY NO. 705-10-7621 | 17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

330X IMMEDIATE CAUSE (A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days +

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) unknown cause
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. General arteriosclerosis.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) no injury reported.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-13, 1955 to 10-1, 1955 that I last saw the deceased alive on 9-30-, 1955, and that death occurred at 6:15 A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeld M.D. ADDRESS Springfield State Hospital DATE SIGNED 10/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10-3-55 | NAME OF CEMETERY OR CREMATORY United Brethren Cem. | LOCATION (City, town, or county) T'burnt (State) Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 2, 1955 | REGISTRAR'S SIGNATURE C. Harry Weer | 24. FUNERAL DIRECTOR M. L. Reagan & Son - T'burnt | ADDRESS

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09643

CERTIFICATE OF DEATH

9636

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Manchester
LENGTH OF STAY (in this place) 9 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Long View Nurs Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester X
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) VIRGIE (Middle) V (Last) NAYLOR

4. DATE OF DEATH: (Month) Oct (Day) 21 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Feb 22 1888 | 9. AGE last birthday: 67 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H Bosley
14. MOTHER'S MAIDEN NAME: Mary E Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: J H Naylor - 4214 Falls Rd - Balto Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X
IMMEDIATE CAUSE (A) Diabetic gangrene leg — INTERVAL BETWEEN ONSET AND DEATH: 1 Months

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Diabetes
(C) DUE TO Cerebral Hemorrhage — 4 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/20/55, 19..., to 10/21/55, 19..., that I last saw the deceased alive on 10/21/55, 19..., and that death occurred at 7P M, from the causes and on the date stated above.

SIGNATURE W H Howard
M. D. ADDRESS Manchester, Md
DATE SIGNED 10/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Oct 24/55
NAME OF CEMETERY OR CREMATORY: Mt Zion
LOCATION (City, town, or county) (State): Bulls Cr Md

DATE REC'D BY LOCAL REGISTRAR: Oct 25 - 55
REGISTRAR'S SIGNATURE: Mrs. Mpl. Denner
24. FUNERAL DIRECTOR: Edw A Tipton
ADDRESS: Hampstead Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9637

CERTIFICATE OF DEATH

09644

Reg. Dist. No. 12

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 4y-11m-7d
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 6, Md. 03X-2
STREET ADDRESS (If rural give location) 6014 Shady Lane, ✓

3. NAME OF DECEASED: (Type or Print) (First) Grace ~~Viona~~ (Middle) Viona (Last) Pscherer

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 7 - 20 - 95

9. AGE last birthday 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Rabold

14. MOTHER'S MAIDEN NAME: Anna Pursell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
203X IMMEDIATE CAUSE	(A) Arteriosclerotic heart dis	years
ANTECEDENT CAUSE (S) DUE TO	Anemia	years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) Multiple myeloma	years
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Involutional psychosis depressed type with some paranoid features	5 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14-, 1955, to 10-22-, 1955, that I last saw the deceased alive on 10-21-, 1955, and that death occurred at 8:15 AM, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M.D. ADDRESS M. D. Springfield State Hospital DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	OCT 24-55	HOLY REDEEMER	4400 BELAIR RD MD

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/25/55	C. W. Hedrick	Dippel Bros	7110 Belair Rd.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9638

CERTIFICATE OF DEATH

09645

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Henryton
LENGTH OF STAY (in this place): 132 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 03 Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis 02-10-2
STREET ADDRESS (If rural give location): 819 West Street ✓

3. NAME OF DECEASED: (First) Joseph (Middle) Benson (Last) Rawlings
4. DATE OF DEATH: (Month) 10 (Day) 2 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower
8. DATE OF BIRTH: 4-12-1912
9. AGE last birthday: 43 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Contractors
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Joseph Rawlings, Jr.
14. MOTHER'S MAIDEN NAME: Mary Calvin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-05-8824
17. INFORMANT & ADDRESS: Joseph B. Rawlings - 819 West Street

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

002X
Immediate cause (a) Hypertensive Cardiovascular Disease
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Minimal bilateral pulmonary tuberculosis
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-23-, 1955, to 10-2-, 1955, that I last saw the deceased alive on 10-2-, 1955, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): J. F. Postal M.D. ADDRESS: Henryton, Maryland DATE SIGNED: 10-2-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: Oct. 6, 1955 NAME OF CEMETERY OR CREMATORY: Chews Chapel LOCATION (City, town, or county) (State): Owensville, Maryland

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE: Albert R. Swandtner

24. FUNERAL DIRECTOR ADDRESS: William Reese, II - 108 Washington St Annapolis, Md.

VS. A15

09646
75

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9639 **CERTIFICATE OF DEATH** Reg. Dist. No. 33

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Manchester
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester X
STREET ADDRESS (If rural give location) Route 1

3. NAME OF DECEASED: (First) Melba (Middle) McAdow (Last) Raycob
4. DATE OF DEATH: (Month) Oct (Day) 25 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: Nov 11 1900
9. AGE last birthday: 54 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frank McAdow
14. MOTHER'S MAIDEN NAME: Grace Stella Snyder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-0156
17. INFORMANT & ADDRESS: Frederick I Raycob Sr Manchester Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

148X Immediate cause (a) Lympho - epithelioma 1yr

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/29 1954, to Oct 25, 1955, that I last saw the deceased alive on Oct 24, 1955, and that death occurred at 4:30 PM, from the causes and on the date stated above.

SIGNATURE W H Hoard (Degree or title) M.D. ADDRESS Manchester, Md. DATE SIGNED 10/25/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct 28 1955 NAME OF CEMETERY OR CREMATORY Manchester Luth Cem. LOCATION (City, town, or county) Manchester (State) Md

DATE REC'D BY LOCAL REGISTRAR 10-27-55 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Wm Berryman & Sons ADDRESS Reisterstown Md

Oct, 30-55 Mrs. WRS Denner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09647

9640 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 9 mos. 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton
STREET ADDRESS (If rural give location) 11264 Old Bladensburg Road

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Mansfield (Last) REED

4. DATE OF DEATH: (Month) 10 (Day) 4 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH: 2/12/70 | 9. AGE last birthday 85 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Nat. Zoo. Park - Govt. Service
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bushrod Reed
14. MOTHER'S MAIDEN NAME: Catherine Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service) -
16. SOCIAL SECURITY NO. Unk -
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X
IMMEDIATE CAUSE (A) Cerebral Thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: 1 Mo. 5 days
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized Arteriosclerosis — years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 1½ years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/29, 1955, to 10/4, 1955 that I last saw the deceased alive on 10/3, 1955, and that death occurred at 4:00 AM EST, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | DATE THEREOF 10/4/55 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) Silver Spring, Md

DATE REC'D BY LOCAL REGISTRAR Oct. 4, 1955 | REGISTRAR'S SIGNATURE C. Harry Weer | 24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09648

9641

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 3Y 6M 12 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Y 0 1-4
STREET ADDRESS (If rural give location) 2421 Maryland Avenue

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) FREDERICK (Last) SCHAEFER

4. DATE OF DEATH: (Month) 10 (Day) 30 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 7/13/76

9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard

10B. KIND OF BUSINESS OR INDUSTRY: Bank - Union Trust

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Schaefer

14. MOTHER'S MAIDEN NAME: Mary —?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic heart disease — years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma of bladder — years; Cr.Br.Syndrome assoc. with senile brain disease 3 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/55, 19..., to 10/30, 19 55 that I last saw the deceased alive on 10/29, 19 55, and that death occurred at 6:15 A M, from the causes and on the date stated above.

SIGNATURE Edmund Gusthaus M. D. ADDRESS Sykesville, Maryland DATE SIGNED 10/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — DATE THEREOF Nov-3-55 — NAME OF CEMETERY OR CREMATORY BALto. — LOCATION (City, town, or county) (State) BALto.

DATE REC'D BY LOCAL REGISTRAR Oct. 31, 1955 — REGISTRAR'S SIGNATURE C. Harry Zeller Jr. — 24. FUNERAL DIRECTOR Cook Sons 1319 St Paul St — ADDRESS

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9642 **CERTIFICATE OF DEATH**

09649

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town) Rural Westminster
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural give location) R.D. 2

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) T. W. (Last) SHERFEY

4. DATE OF DEATH: (Month) Oct. (Day) 10 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Widowed	Nov. 12. 1880	74 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Lab. Labour	Lumber yard	Md.	U.S.A.

13. FATHER'S NAME: Benjamin F. Sherfey

14. MOTHER'S MAIDEN NAME: Lavinia Eyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no		213-05-1705	Mrs Anna Sorrick R.D. 2 Westminster Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4424 Immediate cause	(a) acute Cardiac dilatation	24 hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Cardio Renal disease	1 yr
	DUE TO (c) Arterio Sclerosis	1 yr
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-9-, 1955, to 10-10-, 1955, that I last saw the deceased alive on 10-9-, 1955, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Elias R. Fouts M.D.	Westminster Md	10-11-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 14. 1955	Westminster Cemetery	Westminster Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-11-55	Harvey Mather	C. Bankert Son	Westminster Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9643 **CERTIFICATE OF DEATH** Reg. Dist. No. 09650 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 4/7/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson 15X-2
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED: (Type or Print) (First) Carroll (Middle) Austin (Last) SHREVE

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Sept. 27, 1866

9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Work.

10B. KIND OF BUSINESS OR INDUSTRY: Work.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Daniel T. Shreve

14. MOTHER'S MAIDEN NAME: Margaret Ellen Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn. If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 491X	(A) Bronchopneumonia	10 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) senility	7 years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Psychosis with cerebral arteriosclerosis	7 years

19A. DATE OF OPERATION: ---

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ ---

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from July 16, 1954, to Oct. 9, 1955, that I last saw the deceased alive on Oct. 8, 1955, and that death occurred at 12:30 M, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. M.D. ADDRESS Sykesville, Maryland DATE SIGNED Oct. 9, 1955

Martin Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10/10/55 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) (State) Beallsville Monta. Md

DATE REC'D BY LOCAL REGISTRAR Oct. 9, 1955 | REGISTRAR'S SIGNATURE C. Harry Thaw

24. FUNERAL DIRECTOR William B. Dalton ADDRESS Barnesville, Md

9644

09651 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home - RFD 1, Sykesville

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sykesville Rural
STREET ADDRESS RFD 1 (If rural, give location) Sykesville

3. NAME OF DECEASED: (Type or Print) (First) Vernon (Middle) Lee (Last) Sibert

4. DATE OF DEATH (Month) October (Day) 27 (Year) 19 55

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: Mar - 1904

9. AGE last birthday: 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Weaver

10b. KIND OF BUSINESS OR INDUSTRY: Woolen Mill

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Percy L. Seibert

14. MOTHER'S MAIDEN NAME: Elizabeth Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: Unk -

17. INFORMANT & ADDRESS: Amps Funeral Home - Winchester, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

490X
Immediate cause (a) Lobar Pneumonia, middle and lower lobes right lung.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTINC ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Ford C. Amps M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 10/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 10-31-55

NAME OF CEMETERY OR ~~CREMATORY~~ Mt Nelson

LOCATION (City, town, or county) (State) Winchester, Va.

DATE REC'D BY LOCAL REG. Oct. 28, 1955

REGISTRAR'S SIGNATURE C. Harry Weed

24. FUNERAL DIRECTOR ADDRESS Amps Funeral Home - Winchester, Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09652

9645

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X New Windsor
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Main St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor X
STREET ADDRESS (If rural give location) Main St 1

3. NAME OF DECEASED: (First) GEORGE (Middle) EDWARD (Last) SMITH

4. DATE OF DEATH: (Month) Oct (Day) 18 (Year) 1955

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: March 4. 1876 | 9. AGE last birthday 79 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier | 10B. KIND OF BUSINESS OR INDUSTRY: Retired | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Smith

14. MOTHER'S MAIDEN NAME: Clara C Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: George B Smith New Windsor Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE (A) Chronic Myocarditis
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis with High BP DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: months.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1955, to Oct 18, 1955, that I last saw the deceased alive on Oct 18, 1955, and that death occurred at 5:40 PM, from the causes and on the date stated above.

SIGNATURE J. N Legg M. D. | ADDRESS Union Bridge | DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Oct 21-1955 | NAME OF CEMETERY OR CREMATORY Winters | LOCATION (City, town, or county) (State) Carroll Co, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct 19/55 | REGISTRAR'S SIGNATURE Ernie S Bynedict | 24. FUNERAL DIRECTOR | ADDRESS D D Hartle & Sons, New Windsor, Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09544

9646 CERTIFICATE OF DEATH Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS Star Route

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount
STREET ADDRESS (If rural give location) Star Route

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) W. (Last) SMITH

4. DATE OF DEATH: (Month) Oct. (Day) 5 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: April 3, 1888
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Head Gardner
10B. KIND OF BUSINESS OR INDUSTRY: Gardening
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Smith
14. MOTHER'S MAIDEN NAME: Elizabeth Cromlett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-2017
17. INFORMANT & ADDRESS: Mr. Clyde E. Stouffer-Star Route, Greenmount Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

140X
IMMEDIATE CAUSE (A) Carcinoma of Larynx (Metastatic) — 6 mos
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Carcinoma of Lip — 5 yrs.
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 19 55, to Oct. 5 55, that I last saw the deceased alive on Oct. 5 19 55, and that death occurred at 2 p M, from the causes and on the date stated above.

SIGNATURE M. C. Partridge M. D. ADDRESS Hampstead, Md DATE SIGNED 10-5-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/8/55
NAME OF CEMETERY OR CREMATORY Good Shepherd
LOCATION (City, town, or county) (State) Howard Co., Md.

DATE REC'D BY LOCAL REGISTRAR 10-6-55
REGISTRAR'S SIGNATURE F. C. Hedrick
24. FUNERAL DIRECTOR Wm. J. Tichener & Sons
ADDRESS Md Balto 17

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH

09653

2411 N. Charles Street, Baltimore

9647

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH
COUNTY: Carroll
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural Union Bridge
LENGTH OF STAY (in this place): 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 90 Rowe Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Taneytown X
STREET ADDRESS (If rural, give location): 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	M.	Spangler	October 23, 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
F	W	Widow	July 8, 1870	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own Home	Penna.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ephriam F. Herr	Mary J. Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	Mrs. Dovie Miller, Gettysburg, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
1450.0 Immediate cause (a) Arteriosclerosis	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan 10, 1955 to Oct 22, 1955 that I last saw the deceased alive on Oct 23, 1955, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. H Legg	M D	Union Bridge	10-25-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 26, 1955	Lutheran Cemetery	Harney, Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Oct 26, 1955	Leslie L. Repp	C.O.Fuss & Son, Taneytown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9648

CERTIFICATE OF DEATH

09654

Reg. Dist. No. 87

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural give location) Broadway

3. NAME OF DECEASED: (Type or Print) (First) ESTHER (Middle) PHLENA (Last) STITELY

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 19-55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug. 8-1865

9. AGE last birthday: 90 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joel A. Stitely

14. MOTHER'S MAIDEN NAME: Ellen L. Repp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Carroll Rinehart Westminster, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
450.0
Immediate cause (a) DUE TO Cerebral Sclerosis
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-21, 1955, to 10-22, 1955, that I last saw the deceased alive on 10-22, 1955, and that death occurred at Oct 23-55-6 a.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) J. H. Legg MD — ADDRESS Union Bridge Md. — DATE SIGNED 10-24-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 10/26/55 | NAME OF CEMETERY OR CREMATORY Bungarner Cem. | LOCATION (City, town, or county) Uniontown, (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct. 25, 1955 | REGISTRAR'S SIGNATURE Leslie L. Repp

24. FUNERAL DIRECTOR D. D. Hartle & Sons — ADDRESS Union Bridge, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09655

9649 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 36 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural give location) 1429 Webb Court

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) (Last) Sykes
4. DATE OF DEATH: (Month) 10- (Day) 5- (Year) 1955
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 7-5-1897
9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elizabeth City, N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Silas Sykes
14. MOTHER'S MAIDEN NAME: Mary Jane Bennett
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Walter Sykes - 1429 Webb Court

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

002X
Immediate cause (a) Far advanced bilateral cavitary tuberculosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30-, 1955, to 10-5-, 1955, that I last saw the deceased alive on 10-5-, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE I. F. Postal (Degree or title) M.D ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 10-10-55 NAME OF CEMETERY OR CREMATORY Mt. Albans Cemetery LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-5-55 REGISTRAR'S SIGNATURE Albert R. Swandham

24. FUNERAL DIRECTOR Adolphus Holstead ADDRESS 2118 Will ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09656

9650

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Westminster
LENGTH OF STAY (in this place) 19y 11mo 7days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 0102-2
STREET ADDRESS (If rural give location) not known

3. NAME OF DECEASED: (Type or Print) (First) Edith Lee (Middle) (Last) Tansill

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 2 2 1896

9. AGE last birthday 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Howard Hipsley

14. MOTHER'S MAIDEN NAME: Alice Fellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic heart disease — several years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Paranoid State — 20y +

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jul 1 1955, to October 22 1955, that I last saw the deceased alive on October 22, 1955, and that death occurred at 10:35 p. M, from the causes and on the date stated above.

SIGNATURE Walther H Sonnendecker M. D. ADDRESS Springfield State Hospital DATE SIGNED 10/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-25-55 — NAME OF CEMETERY OR CREMATORY Hill Crest — LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Oct 23, 1955 — REGISTRAR'S SIGNATURE C. Harry Dew

24. FUNERAL DIRECTOR James Scarpelli — ADDRESS Cumberland, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9651

CERTIFICATE OF DEATH

09657

Reg. Dist. No. 3C

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville

LENGTH OF STAY (in this place) 5 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 7 3V01-4

STREET ADDRESS (If rural give location) 5007 Belleville Avenue

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) MERLE (Last) TOTTY

4. DATE OF DEATH: (Month) October (Day) 19 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Sep.

8. DATE OF BIRTH: 5-4-80

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Groc. Store Manager

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland (Baltimore)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Totty

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-03-1540

17. INFORMANT & ADDRESS: Mrs Harry M. Totty 5007 Belleville Av Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 0028

(A) Bronchopneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(B) Tuberculosis of lung, far-advanced — 6 months

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with senile brain disease, with psychotic reaction, plus. pulm. tbc. — 5 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-19, 1955, to 10-19, 1955, that I last saw the deceased alive on 10-18-55, 19, and that death occurred at 3:00AM, from the causes and on the date stated above.

SIGNATURE Edmund Lustman M. D. — ADDRESS Springfield State Hospital — DATE SIGNED 10-19-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Oct. 22 1955

NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery

LOCATION (City, town, or county) (State) Baltimore, Maryland.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Phillips Funeral Home

ADDRESS 4510 Liberty Heights Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09658

9652

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 27Y-3M-11D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural give location) 709 N. Monroe Street

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) (Last) Townsend

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed

8. DATE OF BIRTH: 7 - 8 - 1870

9. AGE last birthday 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) packer

10B. KIND OF BUSINESS OR INDUSTRY: meat packing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Townsend

14. MOTHER'S MAIDEN NAME: Annie E. Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unkn (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unkn

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.1
IMMEDIATE CAUSE

(A) Hemorrhages & Varices.
DUE TO Cirrhosis of the Liver (Laennec). Liver cancer type.

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH
Hemorrhages sudden.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Alcoholic hallucinosis — 27 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2-, 1955, to 10-22-, 1955, that I last saw the deceased alive on 10-21-55, and that death occurred at 8:20 AM, from the causes and on the date stated above.

SIGNATURE Edmund Lusitanus M.D. ADDRESS M. D. Springfield State Hospital DATE SIGNED 10-22-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10-25-55 | NAME OF CEMETERY OR CREMATORY Mt Olivet Cem | LOCATION (City, town, or county) (State) Frederick Md Boro

DATE REC'D BY LOCAL REGISTRAR 10/24/55 | REGISTRAR'S SIGNATURE Asa Hedrick

24. FUNERAL DIRECTOR Thomas J Kenny Inc ADDRESS 1600 Hollins St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09659

9653 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 6 Y, 6 M, 27 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 3401-4

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) WALTERS

4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 2/11/80

9. AGE last birthday 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevedore

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: Martin Walters

14. MOTHER'S MAIDEN NAME: Julie Luziane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.1

IMMEDIATE CAUSE (A) Septicemia — days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Gangrene of the extremity — months

DUE TO (C) Generalized arteriosclerosis — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis — 8 years

19A. DATE OF OPERATION: 10/18/55

19B. MAJOR FINDINGS OF OPERATION: Gangrene of lower left extremity up to knee

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/21, 1955, to 10/28, 1955, that I last saw the deceased alive on 10/28, 1955, and that death occurred at 9:25 AM, EST, from the causes and on the date stated above.

SIGNATURE Walther H. Sommerfeldt M.D. ADDRESS Sykesville, Maryland DATE SIGNED 10/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 11/1/55 — NAME OF CEMETERY OR CREMATORY Sacred Heart — LOCATION (City, town, or county) (State) Denmead Ave Rd

DATE REC'D BY LOCAL REGISTRAR 10/31/55 — REGISTRAR'S SIGNATURE C. M. Aldrich — 24. FUNERAL DIRECTOR J. J. Fahey & Sons — ADDRESS 1318 Light

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09660

9654

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) since 3-1-33
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cumberland
STREET ADDRESS (If rural give location) 01 x-2

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Ellen (Last) Welsh

4. DATE OF DEATH: (Month) October (Day) 7 (Year) 1955

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed
8. DATE OF BIRTH: January 30, 1877
9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Isreal Twigg
14. MOTHER'S MAIDEN NAME: Nancy Ann Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. unk.
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 170X
(A) DUE TO Paget's disease of right breast — INTERVAL BETWEEN ONSET AND DEATH more than 12 years

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Involutional Melancholia — more than 20 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-27-, 1948, to Oct. 7, 1955, that I last saw the deceased alive on Oct. 7, 1955, and that death occurred at 0:30 M, from the causes and on the date stated above.

SIGNATURE Marian Nadolski M. D. ADDRESS Sykesville, Md. DATE SIGNED 10-7-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-11-55
NAME OF CEMETERY OR CREMATORY Cumberland
LOCATION (City, town, or county) (State) Allegany Co. Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 8, 1955
REGISTRAR'S SIGNATURE C. Harry Weed
24. FUNERAL DIRECTOR Stacy Ville Funeral Home ADDRESS Cumberland

MARYLAND STATE DEPARTMENT OF HEALTH

09661

9655

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X rural--Westminster — LENGTH OF STAY (in this place): Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural--Westminster X
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 23	STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print)	(First) EDWARD	(Middle)	(Last) WILLIAMS	4. DATE OF DEATH	(Month) OCT.	(Day) 24,	(Year) 1955
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 9-3-1881	9. AGE last birthday: 74 yrs.	If under 1 year: Months	Days	If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm laborer	10b. KIND OF BUSINESS OR INDUSTRY: farming	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William R. Williams		14. MOTHER'S MAIDEN NAME: Milesann Turfel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT AND ADDRESS: Ella M. Fossett, Westminster, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Coronary Thrombosis	Few hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (Found dead in cornfield)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 10/24, 1955, to 10/24, 1955, that I ~~last~~ saw the deceased alive on ---, 19---, and that death occurred at 10 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
P. Luther Bair	MD Deputy medical Exam	Westminster Md	10/24/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10-27-1955	Deer Park	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-27-1955	E. M. Farver	C. M. Waltz,	Winfield, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09662

9656 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 10 month 3days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 13 3V01-4
STREET ADDRESS (If rural give location) 1110 N. Kenwood Avenue

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) (Last) WILSON

4. DATE OF DEATH: (Month) 10- (Day) 20 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 8-28-86

9. AGE last birthday 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Unk-

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wilson

14. MOTHER'S MAIDEN NAME: Mary Ellen Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk-

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (S) DUE TO (B) Coronary occlusion — days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic heart disease — years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS assoc. with circulatory disturbance, with cere. arteriosclerosis, without qualifying phrase. — Years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4-55, 19..., to 10-20..., 19.55, that I last saw the deceased alive on 10-20..., 19 55, and that death occurred at 9:45 AM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeld M. D. ADDRESS Springfield State Hosp. DATE SIGNED 10-20-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-24-55 — NAME OF CEMETERY OR ~~CREMATORY~~ Baltimore — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 21, 1955 — REGISTRAR'S SIGNATURE C. Henry Ziker

24. FUNERAL DIRECTOR Wm. Cook, Inc. — ADDRESS 1212 E. Pratt St. Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9657 **CERTIFICATE OF DEATH** Reg. Dist. No. 09663 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 9y 8mo 26 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) (Last) WOODEN
4. DATE OF DEATH: (Month) (Day) (Year) 10 - 1 - 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower
8. DATE OF BIRTH: 6-1-65
9. AGE last birthday: #90 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Enos Wooden
14. MOTHER'S MAIDEN NAME: Mary E. Russell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) UNK. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Mrs. Carl Northard (daughter)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis secondary to Arteriosclerosis — years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated arteriosclerosis — years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4 ..., 1946, to 10-1, 1955, that I last saw the deceased alive on 10-1-, 1955, and that death occurred at 6:45 A M, from the causes and on the date stated above.
SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital. DATE SIGNED 10/1/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10-4-55
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 7, 1955
REGISTRAR'S SIGNATURE C. Harry Steer
24. FUNERAL DIRECTOR Wm. Cook, Jr. ADDRESS 1212 Park Ave. Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09664

9658

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural
LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 /

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead - Rural
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) NATHANIEL (Middle) B (Last) WOODY

4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: Feb 22 1882

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farm.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gilbert Woody

14. MOTHER'S MAIDEN NAME: Fannie Saylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ✓

17. INFORMANT & ADDRESS: Mrs N B Woody - Hampstead Md

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260X IMMEDIATE CAUSE	(A) Cerebral Hemorrhage	1 wk
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Arteriosclerotic Heart Disease	5 yrs
	DUE TO (C) Diabetes	3 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 55, to Oct 10 55, that I last saw the deceased alive on Oct 9, 1955, and that death occurred at 2 A M, from the causes and on the date stated above.

SIGNATURE W N Hoard ADDRESS M. D. Manchester, Md DATE SIGNED 10-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Oct 13 55 | NAME OF CEMETERY OR CREMATORY Greenmount | LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR 10/10/55 | REGISTRAR'S SIGNATURE Henry J Reese | 24. FUNERAL DIRECTOR Edw C Tipton | ADDRESS Hampstead Md